

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04341

Reg. Dist. No.

4390

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland			c. LENGTH OF STAY IN 1b 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7628 Hawthorne Street				d. STREET ADDRESS 7628 Hawthorne Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Leonard Last Alvey				4. DATE OF DEATH Month April Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-20	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofing and sider	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward T. Alvey				14. MOTHER'S MAIDEN NAME Rose E Hancock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles E. Alvey; Columbia Park-Landover, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation</p> <p>974x DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging</p> <p>DUE TO (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging by the neck			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 4-16- 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) kentland-- Prince Georges, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED April 16, 1957			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR APR 22 1957			
24b. REGISTRAR'S SIGNATURE Carrie Campbell							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. [illegible]		Male		[illegible]		[illegible]	
Residence		Occupation		Cause of Death		Manner of Death	
[illegible]		[illegible]		[illegible]		[illegible]	
Physician		Hospital		Place of Death		Time of Death	
[illegible]		[illegible]		[illegible]		[illegible]	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[illegible]		[illegible]		[illegible]		[illegible]	

BUREAU V. 3

APR 22 1957

RECEIVED

CERTIFICATE OF DEATH

04342

4391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Carolina</u> b. COUNTY <u>Cumberland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonston</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4902-52nd pl</u>				e. STREET ADDRESS <u>433-Duck St</u>			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Hedley</u> Last <u>Batton</u>				4. DATE OF DEATH Month <u>apr</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>N Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Hubbard</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Vernon Batton Edmonston Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>5 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>apr 14</u> , 19 <u>57</u> , to <u>apr 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>apr 14</u> , 19 <u>57</u> , and that death occurred at <u>445</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>4-16-57</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				<u>Riverdale, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cumberland</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Co North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Buschman Fayetteville, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>H. H. Kennedy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPT. OF HEALTH

BUREAU V. S.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04343**

4392

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2223-Jameson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl First Bauman Middle Bauman Last		4. DATE OF DEATH April 10 1957 Month April Day 10 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH march 22, 1911
9. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Food	11. BIRTHPLACE (State or foreign country) Paris, France
12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME Karl Bauman	
14. MOTHER'S MAIDEN NAME Jeanne E. Gogert		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 578-46-8433		17. INFORMANT Mrs Lena Bauman Address Arlington #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13-57	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sammond Bros		ADDRESS 1661 Good Hope Rd	
24a. REC'D BY REGISTRAR April 15 57		24b. REGISTRAR'S SIGNATURE Arthur	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04344

4338

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3407 Nicholson Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 West Hyattsville	
3. NAME OF DECEASED (Type or print) First Middle Last Francis I Beach		4. DATE OF DEATH Month Day Year April 20, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1876
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pressman, U.S. Govt Printing Office D.C.	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel W. Beach		14. MOTHER'S MAIDEN NAME Sarah Belton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-14-5678-A	
17. INFORMANT Elizabeth H. Beach, wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Senility DUE TO (b) Generalized arteriosclerosis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Hemiplegia & Aphasia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1956, to April 20, 1957, that I last saw the deceased alive on April 18, 1957, and that death occurred at 9:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. S. Fleischer M.D.		ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd DATE SIGNED 4/20/57	
PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER		1440 Howard Ave. Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/24/57	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE April 23 1957	
24b. REGISTRAR'S SIGNATURE Mrs. Jas. S. Sorensen			

CERTIFICATE OF DEATH

1957

1. Name of Deceased: John J. [illegible]
2. Sex: Male
3. Date of Birth: 1911
4. Place of Birth: [illegible]
5. Date of Death: 1957
6. Place of Death: [illegible]
7. Cause of Death: [illegible]
8. Physician: [illegible]
9. Burial Place: [illegible]
10. Signature of Registrar: [illegible]

BUREAU V. E.

APR 25 1957

RECEIVED

4350 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bowie, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Bell</u> Last <u>Bell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Taylor Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Minerva Disney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>chronic myocarditis</u> <u>422.1</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1943</u> 19 <u>April 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>57</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Buell</u>		ADDRESS (Street, city or town, state) <u>402 MAIN ST - LAUREL MD</u>	
PHYSICIAN'S NAME (Type) <u>John R. Buell</u>		DATE SIGNED <u>4/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/8/57</u>	<u>Trinity Cemetery</u>	<u>Patuxent Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md</u>	
24a. REC'D BY REGISTRAR <u>APR 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
4351
Baltimore, Md.
4-15-57
CERTIFICATE OF DEATH

01346

Reg. Dist. No.

745

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 4710 Tecumseh Street			
3. NAME OF DECEASED (Type or print) First KATINKA Middle BARBARA Last BEWLEY				4. DATE OF DEATH Month April Day 23 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 18, 1871 85 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bonnet				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT S. Marguerite Willingmyre, 1918 Edgewater Pkwy,		Address S.Sp.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary Congestion (b) Chr Congestive Heart Failure (c) Atrial - septate Heart Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-15-57 to 4-23-57, that I last saw the deceased alive on 4-23-57, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Etienne, Md.				DATE SIGNED 4/23/57			
PHYSICIAN'S NAME (Type) W. Etienne, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE 29 1957		24b. REGISTRAR'S SIGNATURE James Levey	

BUREAU V. S.

APR 29 1957

RECORDED

4339

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOME				d. STREET ADDRESS #3805 12th. St. N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle L. Last BISHOP				4. DATE OF DEATH Month Apr. Day 19 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-71	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Daniel C. McGivern				14. MOTHER'S MAIDEN NAME Eliza O'Rourke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Fred Koerbel Address Wash. D. C. 5415 Conn. Ave. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 9 1952 to April 19 1957 that I last saw the deceased alive on April 18 1957 and that death occurred at 10:44 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1222 Monroe St NE Washington DC DATE SIGNED APR 22 1957							
ACTUAL SIGNATURE Robert R. Holtz M.D.		PHYSICIAN'S NAME (Type) Robert R. Holtz					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 22/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C. 3822 14th. N.W.				24a. REC'D BY REGISTRAR APR 22 1957		24b. REGISTRAR'S SIGNATURE James L...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

4352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. STREET ADDRESS 2714 Cheverly Avenue			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MAURICE LEROY BITTING				4. DATE OF DEATH Month April Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED WIDOWED NEVER MARRIED		8. DATE OF BIRTH Jan. 1, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 5 Days 1 Hours 57 Min		IF UNDER 24 HRS Months 5 Days 1 Hours 57 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Bitting				14. MOTHER'S MAIDEN NAME Mary Kenep			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 578-10-7131		17. INFORMANT Mrs. Victoria M. Bitting Address 2714 Cheverly Ave., Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 1955 to 4/8/1957 , that I last saw the deceased alive on 2/26/1957 , and that death occurred at 10:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. E. Musser M.D.				ADDRESS (Street, city or town, state) 2409 U. S. & N. W. St.			
DATE SIGNED 4/8/57							
PHYSICIAN'S NAME (Type) FREDERICK E. MUSSER, M.D.				Location Landoner Hills, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 11/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Fr. Deo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.				24a. REC'D BY REGISTRAR DATE APR 11 57		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4353 Items 4353-4354-4355-4356-4357-4358-4359-4360-4361-4362-4363-4364-4365-4366-4367-4368-4369-4370-4371-4372-4373-4374-4375-4376-4377-4378-4379-4380-4381-4382-4383-4384-4385-4386-4387-4388-4389-4390-4391-4392-4393-4394-4395-4396-4397-4398-4399-4400-4401-4402-4403-4404-4405-4406-4407-4408-4409-4410-4411-4412-4413-4414-4415-4416-4417-4418-4419-4420-4421-4422-4423-4424-4425-4426-4427-4428-4429-4430-4431-4432-4433-4434-4435-4436-4437-4438-4439-4440-4441-4442-4443-4444-4445-4446-4447-4448-4449-4450-4451-4452-4453-4454-4455-4456-4457-4458-4459-4460-4461-4462-4463-4464-4465-4466-4467-4468-4469-4470-4471-4472-4473-4474-4475-4476-4477-4478-4479-4480-4481-4482-4483-4484-4485-4486-4487-4488-4489-4490-4491-4492-4493-4494-4495-4496-4497-4498-4499-4500-4501-4502-4503-4504-4505-4506-4507-4508-4509-4510-4511-4512-4513-4514-4515-4516-4517-4518-4519-4520-4521-4522-4523-4524-4525-4526-4527-4528-4529-4530-4531-4532-4533-4534-4535-4536-4537-4538-4539-4540-4541-4542-4543-4544-4545-4546-4547-4548-4549-4550-4551-4552-4553-4554-4555-4556-4557-4558-4559-4560-4561-4562-4563-4564-4565-4566-4567-4568-4569-4570-4571-4572-4573-4574-4575-4576-4577-4578-4579-4580-4581-4582-4583-4584-4585-4586-4587-4588-4589-4590-4591-4592-4593-4594-4595-4596-4597-4598-4599-4600-4601-4602-4603-4604-4605-4606-4607-4608-4609-4610-4611-4612-4613-4614-4615-4616-4617-4618-4619-4620-4621-4622-4623-4624-4625-4626-4627-4628-4629-4630-4631-4632-4633-4634-4635-4636-4637-4638-4639-4640-4641-4642-4643-4644-4645-4646-4647-4648-4649-4650-4651-4652-4653-4654-4655-4656-4657-4658-4659-4660-4661-4662-4663-4664-4665-4666-4667-4668-4669-4670-4671-4672-4673-4674-4675-4676-4677-4678-4679-4680-4681-4682-4683-4684-4685-4686-4687-4688-4689-4690-4691-4692-4693-4694-4695-4696-4697-4698-4699-4700-4701-4702-4703-4704-4705-4706-4707-4708-4709-4710-4711-4712-4713-4714-4715-4716-4717-4718-4719-4720-4721-4722-4723-4724-4725-4726-4727-4728-4729-4730-4731-4732-4733-4734-4735-4736-4737-4738-4739-4740-4741-4742-4743-4744-4745-4746-4747-4748-4749-4750-4751-4752-4753-4754-4755-4756-4757-4758-4759-4760-4761-4762-4763-4764-4765-4766-4767-4768-4769-4770-4771-4772-4773-4774-4775-4776-4777-4778-4779-4780-4781-4782-4783-4784-4785-4786-4787-4788-4789-4790-4791-4792-4793-4794-4795-4796-4797-4798-4799-4800-4801-4802-4803-4804-4805-4806-4807-4808-4809-4810-4811-4812-4813-4814-4815-4816-4817-4818-4819-4820-4821-4822-4823-4824-4825-4826-4827-4828-4829-4830-4831-4832-4833-4834-4835-4836-4837-4838-4839-4840-4841-4842-4843-4844-4845-4846-4847-4848-4849-4850-4851-4852-4853-4854-4855-4856-4857-4858-4859-4860-4861-4862-4863-4864-4865-4866-4867-4868-4869-4870-4871-4872-4873-4874-4875-4876-4877-4878-4879-4880-4881-4882-4883-4884-4885-4886-4887-4888-4889-4890-4891-4892-4893-4894-4895-4896-4897-4898-4899-4900-4901-4902-4903-4904-4905-4906-4907-4908-4909-4910-4911-4912-4913-4914-4915-4916-4917-4918-4919-4920-4921-4922-4923-4924-4925-4926-4927-4928-4929-4930-4931-4932-4933-4934-4935-4936-4937-4938-4939-4940-4941-4942-4943-4944-4945-4946-4947-4948-4949-4950-4951-4952-4953-4954-4955-4956-4957-4958-4959-4960-4961-4962-4963-4964-4965-4966-4967-4968-4969-4970-4971-4972-4973-4974-4975-4976-4977-4978-4979-4980-4981-4982-4983-4984-4985-4986-4987-4988-4989-4990-4991-4992-4993-4994-4995-4996-4997-4998-4999-5000

04349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>4 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Julia Horan</u> First Middle Last				4. DATE OF DEATH <u>April 19 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/11/1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Castle Island, Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>David Horan</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>Andre J. Blancke</u> Address <u>3709-Kennedy Pl. West Hyattsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Auto coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-15</u> , 19 <u>57</u> , to <u>4-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-16</u> , 19 <u>57</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Chamber Co.</u> M.D.				ADDRESS (Street, city or town, state) <u>1432 QUEENS CHAPEL RD</u> DATE SIGNED <u>4/17</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Fleischer</u>				CITY <u>HYATTSVILLE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>W. Hyatts. P. George Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber Co.</u> ADDRESS <u>5801-Cleveland Ave. RIVERDALE MD.</u>				24a. REC'D BY REGISTRAR <u>APR 23 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Chamber</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar promptly to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 03 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4349

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6823 New Hampshire Avenue</u>		e. STREET ADDRESS <u>6723 N. Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George H.</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-72</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Brown</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Flouise Brown</u>	
17. INFORMANT <u>Flouise Brown</u>		Address <u>6723 N. Hampshire</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile dementia of Alzheimer type</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>56</u> , to <u>4-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-6-57</u> , 19 <u>57</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Clum</u> M.D.		ADDRESS (Street, city or town, state) <u>Hyattsville Md</u> DATE SIGNED <u>4-7-57</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Huntman & Son</u>		24a. REC'D BY REGISTRAR DATE <u>4-15-1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Jao. Severo</u>

RECEIVED

APR 16 1957

BUREAU V

4393

CERTIFICATE OF DEATH

Reg. Dist. No.

04351

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Md</u>		c. LENGTH OF STAY IN 1b <u>yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home - Brandywine, Md</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Franklin</u>		4. DATE OF DEATH Month Day Year <u>7/11/57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/19</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas E. Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Thomas E. Byrd</u>		Address <u>Brandywine, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>351x</u> DUE TO <u>B. pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infection & congested Defects</u> DUE TO (c) <u>Spinal Polyps</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-25</u> 19 <u>55</u> , to <u>4-28</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4-25</u> 19 <u>57</u> , and that death occurred at <u>1:40 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.		DATE SIGNED <u>Brandywine, Md</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		<u>Brandywine, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>April 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		24a. REC'D BY REGISTRAR. <u>DATE 3 1957</u>	
ADDRESS <u>Waldorf, Md</u>		24b. REGISTRAR'S SIGNATURE <u>H. J. Hedrick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

MAY 3 1957

RECEIVED

4351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward J. Budzko</u>				4. DATE OF DEATH <u>April 11 1957</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 1, 1899</u>	
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Carmel, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Budzko</u>				14. MOTHER'S MAIDEN NAME <u>Mary ZUKOWSKI</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>"</u>		17. INFORMANT <u>Ignatius Nowakowski</u>		Address <u>RULPMONT PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Gastro-Intestinal hemorrhage</u> DUE TO (b) <u>Ruptured Esophageal Varix</u> DUE TO (c) <u>Portal Cirrhosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 9</u> , 19 <u>57</u> to <u>April 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>57</u> , and that death occurred at <u>10</u> <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4403 28th Place Mt Rainier Md.</u> DATE SIGNED <u>April 11, 1957</u>							
ACTUAL SIGNATURE <u>Sam L. L...</u>				M.D. <u>4403 28th Place Mt Rainier Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Leon R. L...</u>				<u>4403 28th Place Mt Rainier Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>APR 17 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 17 1957

BUREAU V. S.

4394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 5 yrs, 5 mo's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale, Maryland				d. STREET ADDRESS 140 - 12th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle S. Last Burton				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/92	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & manager				10b. KIND OF BUSINESS OR INDUSTRY lunch room		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sherman Burton				14. MOTHER'S MAIDEN NAME Laura Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 225-10-2812		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO 102X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 months 5 1/2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 17, 1952, to April 5, 1957, that I last saw the deceased alive on April 5, 1957, and that death occurred at 7:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. Glenn Dale Hospital, Glenn Dale, Md. 4/5/57 ACTUAL SIGNATURE Moe Weiss PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldo Funeral Home				ADDRESS Washington		24a. REC'D BY REGISTRAR DATE APR 9 '57	
				24b. REGISTRAR'S SIGNATURE W. Leach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU V. S.

BUREAU V. S.

APR 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04355

4396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7300 Block Old Fort Road				d. STREET ADDRESS 8910 Old Fort Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Desayles Last Chew				4. DATE OF DEATH Month April Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1918	
9. AGE (In years last birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Chew				14. MOTHER'S MAIDEN NAME Maggie Queen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [Blank]		17. INFORMANT Maggie Chew, 8910 Old Fort Road, Chapel Hill, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary Tuberculosis (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) [Blank]							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) [Blank]					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) [Blank]		20f. (City or town) (County) (State) [Blank]	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				DATE SIGNED April 26, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) [Blank]		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Berwyn Rd. SE N.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson & Jenkins				24a. REC'D BY REGISTRAR [Blank]			
24b. REGISTRAR'S SIGNATURE [Blank]				DATE May 7 57			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 14 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4355 Item 9 Film G21h 5-1-57 et
CERTIFICATE OF DEATH

Reg. Dist. No.

04356

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5711 Euclid St.</u>				d. STREET ADDRESS <u>15711 Euclid ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>F.</u> Last <u>CHWALEK</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 19, 1893</u>	
9. AGE (In years last birthday) <u>63 1/2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Chwalek</u>				14. MOTHER'S MAIDEN NAME <u>ANTONINA VICTOWSKA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MRS HELENA CHWALEK 5711 Euclid St. Cheverly Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno CARCINOMA OF RECTUM</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>JAN 23, 1956</u> to <u>APRIL 22, 1957</u> , that I last saw the deceased alive on <u>APRIL 22, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Norman Donat Breaux</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Perry St. Mt. Airy Md.</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BREAUX</u>				DATE SIGNED <u>4/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Gasch's Sons Hyattsville Maryland.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

RECEIVED

APR 24 1957

BUREAU V. E.

4397

CERTIFICATE OF DEATH

Reg. Dist. No.

243

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie - Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bowie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Glascoe Colen</u>				4. DATE OF DEATH Month Day Year <u>4 - 13 - 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Neg</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11, 1825</u>	9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Colen</u>				14. MOTHER'S MAIDEN NAME <u>Susan Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rebecca F. Colen</u>		Address <u>Bowie, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene of left foot</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Bowie, md</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Mar 14</u> , 1957, to <u>April 13</u> , 1957, that I last saw the deceased alive on <u>April 13</u> , 1957, and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry A. Wise, Jr.</u>				ADDRESS (Street, city or town, state) <u>149 9th St Bowie md</u>			
PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>				DATE SIGNED <u>4/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/16/57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn</u>		22d. LOCATION (City, town, or county) <u>Wash. D.C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Magruder</u>		ADDRESS <u>2311 Nichols Ave. S.E.</u>		24a. REC'D BY REGISTRAR <u>APR 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Agnes Young</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 15 1937

RECEIVED

4398

CERTIFICATE OF DEATH

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY Pr. Geo's Co. Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Temple Hills Maryland.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home 4450--Whitehall St.		d. STREET ADDRESS 4817-- Leslie Ave., S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE LEMUEL COOK		4. DATE OF DEATH Month Day Year April 11th 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15- 1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer	11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Cook.	
14. MOTHER'S MAIDEN NAME Unknown.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles Ross Cook. 4817- Leslie Ave. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, prostate gland 1771x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis - Congestive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White Not white ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 21, 1949, to April 11, 1957, that I last saw the deceased alive on April 11, 1957, and that death occurred at 1:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leo H. Mugmon M.D. 2711 GAITHICK ST. SE 4/11/57			
ACTUAL SIGNATURE LEO H. MUGMON, M.D.		PHYSICIAN'S NAME (Type) LEO H. MUGMON, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 15-1957	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Linnars Bur.		24a. REC'D BY REGISTRAR DATE 15 1957	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		24c. ADDRESS 1661- Good Hope Road S.E. Washington, D.C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04359

Reg. Dist. No.

4399

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Washington D.C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C. 47x			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3103 Naylor Road S.E.				d. STREET ADDRESS 3601 Wisconsin Ave., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Melville Counsellor				4. DATE OF DEATH Month Day Year April 12, 19 57.			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1895		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Chemical		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME E. M. Counsellor				14. MOTHER'S MAIDEN NAME Elizabeth Diggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 226101070		17. INFORMANT Julliette Counsellor Address Washington D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 12, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/57		22c. NAME OF CEMETERY OR CREMATION Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR APR 17 1957		24b. REGISTRAR'S SIGNATURE Carri Campbell	

RECEIVED

APR 17 1957

BUREAU V. 3

4356

CERTIFICATE OF DEATH

04360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Maryland				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Secorato Rest Home				d. STREET ADDRESS 3205 Cheverly Avenue, .			
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Adam Davis				4. DATE OF DEATH Month Day Year April 28, 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1878	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maine	
13. FATHER'S NAME Frances Adams				12. CITIZEN OF WHAT COUNTRY? U S A			
14. MOTHER'S MAIDEN NAME Jennie Cummings				17. INFORMANT Helen D. Bailey Cheverly, Maryland.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Vascular Accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>2 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old unhealed fracture of hip. 5 yrs</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <i>Jan 1957</i> to <i>27 April 1957</i> , that I last saw the deceased alive on <i>27 April 1957</i> , and that death occurred at <i>Md</i> from the causes and on the date stated above. ADDRESS (Street, city or town, State) DATE SIGNED ACTUAL SIGNATURE <i>John K. Kohr</i> M.D. <i>John K. Kohr M.D.</i> PHYSICIAN'S NAME (Type) <i>Cheverly, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. Gasch's Sons Hyattsville, Md.				24a. REC'D. BY REGISTRAR DATE <i>APR 30 1957</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04361

4357

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden Md.	
c. LENGTH OF STAY IN 1b 10 Hrs.		d. STREET ADDRESS Lestly Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pedro Middle DeCostello Last DeCostello		4. DATE OF DEATH Month April Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-74
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months 73 Days 23 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? ??	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mary (Wife)		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intercranial hemorrhage DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 24 hours ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 22 , 19 57 , to April 23 , 19 57 , that I last saw the deceased alive on April 22 , 19 57 , and that death occurred at 2:01 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. J. Davis		ADDRESS (Street, city or town, state) Washington, D.C.	
PHYSICIAN'S NAME (Type) McQuinn Conn.		DATE SIGNED 4/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4/29/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros.		ADDRESS 621 Fla Ave NW	
24a. REC'D BY REGISTRAR MAY 3 '57		24b. REGISTRAR'S SIGNATURE W. H. Houch	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1957

BUREAU V. E.

4358

CERTIFICATE OF DEATH

Reg. Dist. No.

04302

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>14508 Emerson St.</u>			
3. NAME OF DECEASED (Type or print) <u>Clifton Fritter Edward</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-98</u>	
9. AGE (In years last birthday) <u>58</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Louis Aden</u>			
14. MOTHER'S MAIDEN NAME <u>Rose Fritter</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Hospital Records Riverdale Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Uremia</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular Renal Dis.</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Sept 1954</u> to <u>Apr 28, 1957</u> , that I last saw the deceased alive on <u>Apr 28, 1957</u> , and that death occurred at <u>442X</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u>				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u>			
DATE SIGNED <u>4-28-57</u>							
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. D'Arcy</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>James E. Levey</u>	
				DATE <u>5-1-57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4340

CERTIFICATE OF DEATH

Reg. Dist. No.

04363
245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>621 Sheridan St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>C</u> Last <u>Earnest</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1899</u>		9. AGE (If years lost birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>57</u> Min.	IF UNDER 24 HRS. Hours <u>57</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store Fictive</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Earnest</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Goldberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or status of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ruth Earnest</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug</u> , 1952, to <u>April 3, 1957</u> ; that I last saw the deceased alive on <u>April 3</u> , 1957, and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Dessoff</u> M.D.				ADDRESS (Street, city or town, state) <u>1302-18 St. N.W. Wash. D.C.</u>			
DATE SIGNED <u>4/3/57</u>							
PHYSICIAN'S NAME (Type) <u>SAMUEL DESSOFF</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Danzansky Sons</u>				ADDRESS <u>3501 14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>April 6 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>							

RECEIVED

PR 8 1957

BUREAU V. S.

4400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colman Manor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3903 Colman Manor X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3903 - Laurence St.</u>		d. STREET ADDRESS <u>3903 - Laurence St.</u>	
3. NAME OF DECEASED (Type or print) <u>ALICE SALLIE ENNIS</u>		4. DATE OF DEATH Month <u>APR</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-95</u>
9. AGE (In years lost birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Eys</u>		14. MOTHER'S MAIDEN NAME <u>Lena Ennis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Ellsworth Ennis</u>		Address <u>3903 - Laurence St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>470.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH, 1956</u> , to <u>24 APRIL</u> , 1957, that I last saw the deceased alive on <u>22 APRIL</u> , 1957, and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Maloney</u> M.D.		ADDRESS (Street, city or town, state) <u>4814-71st Ave Landover Hills Md 20401</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY M.D.</u>		DATE SIGNED <u>4/24/57</u>	
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Stafford Co. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm W. Chamberlaine Co. 517-11 St. S.E.</u>		24a. REC'D BY REGISTRAR <u>APR 29 1957</u>	24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 22 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4359 CERTIFICATE OF DEATH

04365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General		d. STREET ADDRESS 4207 55th Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Betty Evans		4. DATE OF DEATH Month Day Year April 10 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-57
9. AGE (In years last birthday) 3 W Years		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mc Ney Wilma (Foster Mother) Same as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parietal subdural hematoma, bilateral DUE TO (c) Intercerebral hemorrhage, right occipital lobe			INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 weeks 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/10 1957 to 4/10 1957, that I last saw the deceased alive on 4/10 1957, and that death occurred at 11:32 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md.	
DATE SIGNED 4/13/57			
PHYSICIAN'S NAME (Type) Dr. J Perkins			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF April 1957	22c. NAME OF CEMETERY OR CREMATORY Prince Georges Landings	22d. LOCATION (City, town, or county) (State) Cheverly Md
23. FUNERAL DIRECTOR'S SIGNATURE William W Perkins		ADDRESS 4207 55th Ave	
24a. REC'D BY REGISTRAR DATE APR 17 '57		24b. REGISTRAR'S SIGNATURE W. Perkins	

RECEIVED

APR 17 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4360

04366

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 17 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph L. Middle Farren Last Farren				4. DATE OF DEATH Month April Day 21 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-01	9. AGE (In years last birthday) 55 56 yrs	10. UNDER 1 YEAR Months 55 Days 56 Hours 01 Min.	11. BIRTHPLACE (State or foreign country) Indiana	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Philip L. Farren				14. MOTHER'S MAIDEN NAME Florence James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, at, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. REDACTED			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 20 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 21, 1957 to APRIL 21, 1957 , that I last saw the deceased alive on APRIL 21, 1957 , and that death occurred at 6 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE DATE SIGNED APRIL 22 1957							
ACTUAL SIGNATURE Samuel J. N. Sugar M.D. 4300 KAYWOOD DRIVE APRIL 22 1957							
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR M.D. 147 RAINIER MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR APR 25 57			
24b. REGISTRAR'S SIGNATURE Alfred				DATE			

BUREAU V. 8

72-5 1957

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Cheverly Manor			
f. STREET ADDRESS 6325 Kilmer Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catherine Middle Margaret Last Fitzpatrick				4. DATE OF DEATH Month April Day 21, Year 19 57.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME James Quill				14. MOTHER'S MAIDEN NAME Johanna Monahan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT William Fitzpatrick; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 21, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR APR 22 '57	
						24b. REGISTRAR'S SIGNATURE Q. J. Leach	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04368

Reg. Dist. No.

4362

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, D.C. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 212 Oakwood Street S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton Middle Freeman Last				4. DATE OF DEATH Month April Day 29 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1895	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Yard		11. BIRTHPLACE (State or foreign country) Ind.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Unk.		16. SOCIAL SECURITY NO. 256-10-2524		17. INFORMANT Carrie L. Freeman Address Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that was in an head on collision					
20c. TIME OF INJURY Month, Day, Year 4/29/1957 Hour a. m. 3:19 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) Upper Marlboro P.G. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Noturol causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 29, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Frager's Funeral Home				ADDRESS 389 Woodlawn Ave		24a. REC'D BY REGISTRAR DATE MAY 3 57	
				24b. REGISTRAR'S SIGNATURE Quinn			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 3 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4337

CERTIFICATE OF DEATH

Reg. Dist. No.

04369

230

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4611 Ambler Road</u>				d. STREET ADDRESS <u>4611 Ambler Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Esther Gordon</u>				4. DATE OF DEATH Month Day Year <u>April 25 1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1872</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas A. Mayes</u>				14. MOTHER'S MAIDEN NAME <u>Rachael Duboise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Myrtella G. Gemeny</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis & hardening of arteries</u> DUE TO (c) <u>13 month</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov. 4</u> , 19 <u>57</u> , to <u>April 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>57</u> , and that death occurred at <u>2:40</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J. R. Roedy</u> M.D. <u>3701 Selma St</u> <u>4-25-57</u> PHYSICIAN'S NAME (Type) <u>J. R. Roedy M.D.</u> <u>Chen Chow MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-27-57</u>		<u>Congressional Cemetery</u>		<u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 66 Ave NW</u>		24a. REC'D BY REGISTRAR <u>APR 30 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Smith</u>			

RECEIVED

APR 30 1957

BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,2,5,6,7,9. Film Q215 5-15-57 et
4401
CERTIFICATE OF DEATH

04370

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY <i>Prince Geo, MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince Geo</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakeland</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakeland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>				d. STREET ADDRESS <i>---</i>			
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Henry</i> Last <i>Gray</i>				4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Approx. 77 yrs</i>	
9. AGE (In years last birthday) <i>77</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>High blood pressure</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>6 yrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>stenosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 27, 1957</i> to <i>April 28, 1957</i> , that I last saw the deceased alive on <i>April 28, 1957</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>April 28, 1957</i>							
ACTUAL SIGNATURE <i>W. S. Hudson</i> M.D.				PHYSICIAN'S NAME (Type) <i>W. S. HUDSON</i> <i>LAUREL MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		22b. DATE THEREOF <i>5/2/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>LINCOLN MEMORIAL</i>		22d. LOCATION (City, town, or county) (State) <i>MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>24 Ernest Jarvis Co 1432 7th St NW</i>				24a. REC'D BY REGISTRAR <i>MAY 1 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mullin Braslow</i>	

RECEIVED

MAY 1 1967

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

245

4363

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2800 Colubrahe Drive S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rutgers Island Memorial Hosp.</u>		d. STREET ADDRESS <u>Hillcrest Hts. Md.</u>	
3 NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Bentrie</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1957</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14 1877</u> 9. AGE (In years last birthday) <u>79</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John William Cook</u>		14. MOTHER'S MAIDEN NAME <u>Phedra Sinclair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 26, 1957</u> , to <u>Apr 9, 1957</u> , that I last saw the deceased alive on <u>Apr 8, 1957</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riversdale, Md.</u> DATE SIGNED <u>4-9-57</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Kansas City</u>	22d. LOCATION (City, town, or county) (State) <u>Missouri</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>APR 11 1957</u> 24b. REGISTRAR'S SIGNATURE <u>James E. Green</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 11

APR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01372

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23rd and East-West Highway		d. STREET ADDRESS 8108 Tahona Drive	
3. NAME OF DECEASED (Type or print) First Joseph Middle Hais Last		4. DATE OF DEATH Month April Day 4th Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 1890 January 25, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Norman Vigderhous		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Harry I. Hais; 9518 Biltmore Drive, Springs, Md.		Address Silver	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Md.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) deceased Automobile driven by deceased in collision with another	
20c. TIME OF INJURY Month, Day, Year 10.00 4-4-1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Hyattsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. M. loney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. M. loney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/57	
22c. NAME OF CEMETERY OR CREMATORY Adas Israel		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dunganovsky + sons - 3501 14th St. N.W.		24a. REC'D BY REGISTRAR April 6 1957	
		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy	

RECEIVED

APR 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4492

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04373

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville				c. LENGTH OF STAY IN 1b Transient			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 50(new) near 301				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Robert Last Haley				4. DATE OF DEATH Month April Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/33	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman				10b. KIND OF BUSINESS OR INDUSTRY U. S. Airforce		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Francis Haley				14. MOTHER'S MAIDEN NAME Ethel Alberta Landyunt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes In now				16. SOCIAL SECURITY NO.			
17. INFORMANT U. S. Airforce Records, U.S. Airforce				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound fracture of the skull, crushed chest and DUE TO (c) abdomen							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that got out of control and turned over			
20c. TIME OF INJURY Month, Day, Year 4/7/ 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) New Rt # 50		20f. (City or town) (County) (State) Mitchellville P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED April 7, 1957			
EXAMINER'S NAME (Type) James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park, Michigan		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS 517-11 St. N.E.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Regina Gungl			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
APR 11 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

4361

1. PLACE OF DEATH a. COUNTY Prince Georges				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,				c. LENGTH OF STAY IN 1b 1 Day				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince Georges				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Bowie															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General								d. STREET ADDRESS 908 Maple Avenue,.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last Helen C. Hansen				4. DATE OF DEATH Month Day Year April 3 19 57				5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Feb. 10-1898				9. AGE (In years last birthday) yrs 59				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife								10b. KIND OF BUSINESS OR INDUSTRY own home								11. BIRTHPLACE (State or foreign country) Maryland								12. CITIZEN OF WHAT COUNTRY? U S A											
13. FATHER'S NAME William W. Phelps												14. MOTHER'S MAIDEN NAME Capitola Johnson																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no								16. SOCIAL SECURITY NO. none								17. INFORMANT H A Hansen Bowie, Maryland.								Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, left. X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)																INTERVAL BETWEEN ONSET AND DEATH 2 weeks years																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19												20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from April 2, 1957, to April 3, 1957, that I last saw the deceased alive on April 3, 1957, and that death occurred at 9:00 P. M. from the causes and on the date stated above.																																			
ACTUAL SIGNATURE Leon R. Levitsky												M.D. 4300 Kaywood Drive Mt. Rainier, Md 4/5/57																							
PHYSICIAN'S NAME (Type) Dr. Leon Levitsky												4300 Kaywood Drive Mt. Rainier, Md.																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF 4/6/57								22c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cemetery								22d. LOCATION (City, town, or county) Collington Maryland.											
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons												ADDRESS Hyattsville, Maryland.												24a. REC'D BY REGISTRAR DATE APR 8 57				24b. REGISTRAR'S SIGNATURE [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 8 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2301 Tacoma Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roland Royland First Middle Last 4. DATE OF DEATH April 16, 1957		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-3-09 9. AGE (In years) 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator 10b. KIND OF BUSINESS OR INDUSTRY constructio 11. BIRTHPLACE (State or foreign country) W. Virginia 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Mansfield Harrah 14. MOTHER'S MAIDEN NAME Susie Adkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) NOVE 16. SOCIAL SECURITY NO. 228-09-7091 17. INFORMANT Edith Harrah; same address Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxia 9123 DUE TO Compression of chest and abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Bulldozer falling on body and pinning him beneath PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A bulldozer that was being driven onto a truck by deceased flipped over backwards pinning him beneath.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month Day Year Hour 6:45 p. m. 4-16-57 19 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Greenbelt 20f. (City or town) Greenbelt (County) Pr. Geo. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.	
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 17, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 4-20-57 22c. NAME OF CEMETERY OR CREMATORY London Park 22d. LOCATION (City, town, or county) BALTIMORE (State) Md		23. FUNERAL DIRECTOR'S SIGNATURE <i>George R. Schuch</i> ADDRESS <i>2101 Frederick Ave Balt</i> 24a. REC'D BY REGISTRAR <i>W. L. Smith</i> 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04376

Reg. Dist. No.

224

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> c. LENGTH OF STAY IN 1b <u>10 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1223 48th Avenue</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) - a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> d. STREET ADDRESS <u>1223 48th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Robert Hudson</u>			4. DATE OF DEATH Month Day Year <u>April 25, 19 57</u>									
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 19, 1864</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Piano finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>								
13. FATHER'S NAME <u>Charles Hudson</u>			14. MOTHER'S MAIDEN NAME <u>Mary Tim</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Edith Hudson same as # 2</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442 X</u> DUE TO </td> <td rowspan="3" style="width: 20%; vertical-align: middle; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442 X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442 X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								
20f. (City or town)		(County)		(State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>James I. Boyd</u>			DATE SIGNED <u>April 25, 1957</u>									
EXAMINER'S NAME (Type) <u>James I. Boyd</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-27-57 Lee's Crematorium - Wash DC</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY								
22d. LOCATION (City, town, or county)		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - 2</u>								
24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>		24c. REGISTRAR'S SIGNATURE <u>APR 25 1957</u>										

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

BUREAU V. H.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

44114

CERTIFICATE OF DEATH

04377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>			
c. LENGTH OF STAY IN 1b <u>2-YRS-</u>				d. STREET ADDRESS <u>5018 Wilson ST. S.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna Mae</u> Middle <u>JENKINS</u> Last <u>JENKINS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 1, 1888</u>	
9. AGE (In years last birthday) <u>68 4/4</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Henry Wan.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rankin Warr.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Ronald W. Jenkins</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>23rd Parkway</u>				20g. (County) <u>SE</u>		20h. (State) <u>57</u>	
21. I certify that I attended the deceased from <u>4-13-1957</u> to <u>4-30-1957</u> that I last saw the deceased alive on <u>4-30-1957</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>5731 23rd Parkway SE 57</u> DATE SIGNED <u>4-30-57</u>							
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D. <u>5731 23rd Parkway SE 57</u>							
PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 3-1957</u>		<u>Fort Lincoln</u>		<u>Calverley Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Son & Son</u> ADDRESS <u>W. Wash. D.C.</u>							
24a. REC'D BY REGISTRAR <u>6</u>				24b. REGISTRAR'S SIGNATURE <u>6</u>			

RECEIVED
MAY 6 1957
BUREAU V. A.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04378

4405 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Prince George</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Prince George</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Ridgeway Estates</i>		TOWN <i>Suitland</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>15 Weber Drive</i>		<i>3202 Logan St.</i>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>BRADLEY Thomas Johnson, SR.</i>		<i>April 17, 1957</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>Jan 4, 1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Street Lighting</i>		<i>PEPCO-</i>	<i>Washington, D.C.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Unknown</i>		<i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>Unknown</i>	
15. INFORMANT & ADDRESS			
<i>Bradley T. Johnson Jr. Son</i>			
16. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			<i>1 yr.</i>
440X IMMEDIATE CAUSE (A) <i>Renal Insufficiency (Uremia)</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Renal Arterio Sclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Alcohol, Malnutrition</i>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 5, 1957</i> to <i>April 17, 1957</i> , that I last saw the deceased alive on <i>Apr 16, 1957</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Edward A. Galant</i>		DATE SIGNED <i>4/17/57</i>	
ADDRESS (Street, city, town, state) <i>5203 S. 16th St. WILMINGTON, DE</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>April 20, 1957</i>	<i>Washington National</i>	<i>Suitland, Maryland</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>d. H. Hedrick</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Washington, D.C.</i>	
DATE <i>APR 22 1957</i>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-11

BUREAU V. 2

APR 22 1957

RECEIVED

4342

CERTIFICATE OF DEATH

Reg. Dist. No.

445

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bell Nursing Home</u>				d. STREET ADDRESS <u>Aeger Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ann Louise Jones</u>				4. DATE OF DEATH Month Day Year <u>April 6, 19 57.</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1956</u>	9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Griffith Jones</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Bell Nursing Home Hyattsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute upper respiratory infection</u> <u>704.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia</u> DUE TO (c) <u>Meningoencephalitis - congenital heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 hours</u> <u>from birth</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/15</u> , 19 <u>56</u> , to <u>4/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/6</u> , 19 <u>57</u> , and that death occurred at <u>4:55</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>College Park, Md 4/6/57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 11 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>James L. Jones</u>			

RECEIVED
APR 11 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4366

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04380

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroll Middle Jones Last Jones		4. DATE OF DEATH Month April Day 21 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-10-11
9. AGE (in years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 45 Days 45 Hours 45 Min. 45	IF UNDER 24 HRS. Months 45 Days 45 Hours 45 Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Janie Lancaster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. William Jones, Jr., 521 Swann Street, D.C.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident . DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 21, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-25-57		22b. DATE THEREOF Queens Chapel	
22c. NAME OF CEMETERY OR CREMATORY Monkirk Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		ADDRESS Sno 467 N of 10th St	
24a. REC'D BY REGISTRAR 24 1957		24b. REGISTRAR'S SIGNATURE James	

BUREAU V. S.

APR 24 1957

RECEIVED

4496

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (Rural)		c. LENGTH OF STAY IN 1b 2 months, 25 days/		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 445 Franklin St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fred Middle Last Jones				4. DATE OF DEATH Month April Day 17 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1890		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruff Jones				14. MOTHER'S MAIDEN NAME Kitty Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Lost		17. INFORMANT Address Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of the esophagus with 150X DUE TO metastasis to ribs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, 6 months							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from January 23, 1957, to April 17, 1957, that I last saw the deceased alive on April 17, 1957, and that death occurred at 2:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale Hospital, Glenn Dale, Md. 4/17/57 PHYSICIAN'S NAME (Type) Moe Weiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4/18/57		22c. NAME OF CEMETERY OR CREMATORY ✓		22d. LOCATION (City, town, or county) (State) ✓	
23. FUNERAL DIRECTOR'S SIGNATURE Malcolm Schreyer 424 R St NW Shirley B Fisher				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

PR 22 1957

BUREAU V. K.

4343

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>DC</u> c. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Nyattsville Rest House</u>		d. STREET ADDRESS <u>1228 Eye St. NW</u>	
3. NAME OF DECEASED (Type or print) <u>HYMAN</u> First <u>KLEIN</u> Middle Last		4. DATE OF DEATH <u>April</u> Month <u>7</u> Day Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u>	
11. BIRTH PLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Avigdor Hersh</u>		14. MOTHER'S MAIDEN NAME <u>? Shaine Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>195-07-3734</u>	
17. INFORMANT <u>Ellis Klein Son 1228 Eye St. NW</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Hypostatic pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>12-10-56</u> <u>12</u> <u>10</u> <u>1956</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> 19 <u>56</u> , to <u>April 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>57</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold F. McCann</u> M.D. <u>3008-14th N.W. Wash. D.C.</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD F. MCCANN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Mem. Ceme.</u>	22d. LOCATION (City, town or county) (State) <u>Nyattsville MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash DC</u> ADDRESS		24a. REC'D BY REGISTRAR <u>April 10, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> Deputy.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1907

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04383

4477

CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sent Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sent Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5959 Rollins Ave.</u>				d. STREET ADDRESS <u>5979 Rollins Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>CECELIA</u> Last <u>KLOTZ</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 30, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Roussillon</u>				14. MOTHER'S MAIDEN NAME <u>Marie Chalambeau</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Marie Lushbury</u> Address <u>5959 Rollins Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>						<u>15 years</u>	
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>Pulmonary Fibrosis</u>	
						DUE TO	
						(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1952</u> to <u>April 5, 1957</u> that I last saw the deceased alive on <u>April 5, 1957</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>4/5/57</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				<u>Capitol Heights Md</u>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat. Cemetery</u>		22d. LOCATION (city, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee & Sons Co. 300 4th St. N.E. Wash. D.C.</u>				24a. RECEIVED BY REGISTRAR DATE <u>APR 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

RECEIVED

APR 9 1957

BUREAU V. S.

4408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Kentucky Ave, Parkland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkland, X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>25 Kentucky Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>MRS. HELEN VIRGINIA KOBER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hiram Wolty</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Suite</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Paul M. Kober, son</u>			
				Address <u>Parkland, Maryland.</u> <u>25 Kentucky Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIO-RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CHRONIC MYELOID LEUKEMIA</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u> <u>4 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 12, 1957</u> to <u>APRIL 8, 1957</u> , that I last saw the deceased alive on <u>APRIL 5, 1957</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7200 MARLBORO RD.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>John E. Ford</u> M.D. <u>7200 MARLBORO RD.</u>				PHYSICIAN'S NAME (Type) <u>JOHN E. FORD</u> <u>DISTRICT HEIGHTS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>				ADDRESS <u>Wash. D.C.</u> <u>1300-N St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Ford</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ACUTE CHRONIC KIDNEY FAILURE
MURKIN MURKIN MURKIN

APRIL 27 1957
JULIAN V. B.

7500 MARLBORO RD.
DISTRICT HOSPITAL, N.Y.
1957

RECEIVED

APRIL 27 1957
John R. Ford
6000 C. ROAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4409

CERTIFICATE OF DEATH

Reg. Dist. No.

04385
245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rum-Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>			
c. LENGTH OF STAY IN 1b <u>1 year</u>				d. STREET ADDRESS <u>4012 Bunker Hill Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Myrtle</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rooming House Operator - Seaside</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Pounds</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gutridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>1703 Allen</u> Address <u>4012 Bunker Hill Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 1, 1956</u> to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>March 25, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitbeck</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>4-1-57</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Park 12 Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Wash. D.C.</u> ADDRESS <u>Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>APR 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James Seaver</u>	

BUREAU V. S.

APR 4 1957

RECEIVED

05492

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

BUREAU V. S.

MAY 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04386

Reg. Dist. No. *245*

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville c. LENGTH OF STAY IN 1b transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colesville Road				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville d. STREET ADDRESS 3305 Rutgers Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert Paul Long First Middle Last				4. DATE OF DEATH April 14, 1957 Month Day Year					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1947		9. AGE (In years last birthday) 9 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School-boy 10b. KIND OF BUSINESS OR INDUSTRY None, Minor Child				11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Robert Walter Long				14. MOTHER'S MAIDEN NAME Irene Grindle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Irene Long Address 3305 Rutgers St., Hyattsville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell into a well through a hole in the floor of the covered					
20c. TIME OF INJURY Month, Day, Year 1.00 Hour 4-14- 19 57 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Private estate		20f. (City or town) W. Hyattsville, Pr. Geo. Md. (County) house (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.									
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 14, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.		22d. LOCATION (City, town, or county) Neat Barton, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.				24a. RECEIVED BY REGISTRAR APR 22 1957 DATE					

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded by the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

SEP 22 1957

BUREAU V. 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rosaryville c. LENGTH OF STAY IN lb 7 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosaryville and Frank J. Tippitt Rd Rosaryville and Frank J. Tippitt Rd						2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville d. STREET ADDRESS Rosaryville and Frank J. Tippitt Rd IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last Frank Raymond Martin 4. DATE OF DEATH Month Day Year April 23 1957																					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 22, 1908		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Employee) Electronics						10b. KIND OF BUSINESS OR INDUSTRY Electronics						11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Martin						14. MOTHER'S MAIDEN NAME Edna Loeb															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II						16. SOCIAL SECURITY NO. 577-52-3363						17. INFORMANT Mrs. Jane Martin same as # 2 Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE James T. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/23/57				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type or print) James T. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/26/57				22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem: Fort Myer, Virginia.				22d. LOCATION (City, town, or county) (State)									
23. FUNERAL DIRECTOR'S SIGNATURE Upper Marlboro, Md. Kitchie Brothers Funeral Home																		24a. REC'D BY REGISTRAR DATE 4/23/57		24b. REGISTRAR'S SIGNATURE D. H. Dedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. No burial, cremation, or removal of the body is permitted until the transit permit is received.

BUREAU V. S.

1957

RECEIVED

4368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GENERAL HOSPITAL		d STREET ADDRESS 3300 OTIS ST.	
3. NAME OF DECEASED (Type or print) First CLAUDE Middle R. MASON Last		4. DATE OF DEATH Month APRIL / Day 13 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-97
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Street Sup. Wash. Gas Light Co.		10b. KIND OF BUSINESS OR INDUSTRY W. Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Mason		14. MOTHER'S MAIDEN NAME Rosa Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Chloee Melintz 3511 Davenport St. N.W.	
17. INFORMANT Address Mrs. Chloee Melintz 3511 Davenport St. N.W.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS 410 A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE FATTY METAMORPHOSIS WITH EARLY SCARRING DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10 , 19 57 , to 13 APRIL , 19 57 , that I last saw the deceased alive on 12 , and that death occurred at 4:25 AM , from the causes and on the date stated above By Dr. George Hageage Paul J. Oviato M.D. ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 4-16-57			
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			
22d. LOCATION (City, town, or county) (State) Prince Georges Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S. F. Hines Co 2901-14th St. N.W.			
24a. REC'D BY REGISTRAR DATE APR 17 57			
24b. REGISTRAR'S SIGNATURE W. H. H. H.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1907

RECEIVED

4412

CERTIFICATE OF DEATH

04391

Reg. Dist. No.

739

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural - Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bamie - Laurel Rd.</u>				e. STREET ADDRESS <u>Bamie Laurel Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Sally Marie</u> First Middle Last <u>Merkel</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 3, 1912</u> 45 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Independence, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank M. Babbitt</u>				14. MOTHER'S MAIDEN NAME <u>Maudie Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward E. Merkel, Laurel Rd</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Breast</u> DUE TO (c) <u>Scirrhous Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>57</u> to <u>4/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/20/57</u> , 19 <u>57</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>4/22/57</u>							
ACTUAL SIGNATURE <u>J M Warren</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN M. WARREN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/23/57</u>		<u>Mt Zion Cemetery Highland Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Randolph, Laurel Rd</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thelma Bruckner</u>	

15M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 24 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04389

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Washington D.C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		c. LENGTH OF STAY IN 1b Transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 210		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
3. NAME OF DECEASED (Type or print) Herbert Asbury Michael		f. STREET ADDRESS 2759 Nichols avenue S. E.	
4. DATE OF DEATH Month April Day 12th Year 1957	g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 20, 1925
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic Capital Air Lines		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles E. Michael		14. MOTHER'S MAIDEN NAME Zourie C. Grove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Norman E. Michael		Address 3758 W Street N W Washington D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the skull, crushed abdomen and chest DUE TO (c) Compound comminuted fracture of both legs, fractures of both forearms			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) tree Occupant of an automobile that ran of the road and struck /	
20c. TIME OF INJURY Month, Day, Year Hour 11:50 p.m. 4/11/57		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 211	
20e. (City or town) Accokeek		20f. (County) P. G.	
20g. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16- 57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, lawn, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR DATE APR 15 1957	
24b. REGISTRAR'S SIGNATURE Carrie Campbell			

BUREAU V. S.

1907

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4369

CERTIFICATE OF DEATH

04390

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly Md.		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.	
c. LENGTH OF STAY IN 1b 5 Days		d. STREET ADDRESS 11110 Montgomery Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Baby Girl Bonnie E. Miller		4. DATE OF DEATH April 25 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-57
9 AGE (In years last birthday) 5 days		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Id	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Noland P Miller		14. MOTHER'S MAIDEN NAME Dorothy Knauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Noland P Miller		Address Beltsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute mediastinitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Esophageal anastomosis DUE TO (c) Repair of Esophageal atresia			INTERVAL BETWEEN ONSET AND DEATH Long interval defied
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		ADDRESS (Street, city or town, state) College Park, Md.	
NAME (Type) Dr. Ware & Dr. Christensen		DATE SIGNED 4/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/57	22c. NAME OF CEMETERY OR CREMATORY Trinity Church Cemetery	22d. LOCATION (City, town, or county) (State) Bowie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE APR 30 1957	
		24b. REGISTRAR'S SIGNATURE Dr. Ware	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 30 1957

BUREAU V. S.

4413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halls		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 301				d. STREET ADDRESS 3545 Greenmount Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Benjamin Last Mouery				4. DATE OF DEATH Month April Day 27 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1924		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Mouery				14. MOTHER'S MAIDEN NAME Ida Cusic			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) In service		17. INFORMANT Papers on person		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed abdomen (c) DUE TO cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran off road and turned over					
20c. TIME OF INJURY Month, Day, Year 3:12 p. m. 4/27/1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 301		20f. (City or town) Hall	(County) Pr. Geo.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 27, 1957	
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/27/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR / DATE APR 30 '57	
				24b. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

BUREAU V. S.

APR 30 1957

RECEIVED

4414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook Acres				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook Acres, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 9404 - Tuckerman St				d. STREET ADDRESS 9404 Tuckerman St			
3. NAME OF DECEASED (Type or print) First Middle Last George ROBERT Mullinix				4. DATE OF DEATH April 21, 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Clerk				10b. KIND OF BUSINESS OR INDUSTRY Esso Standard Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME George Ellsworth Mullinix				14. MOTHER'S MAIDEN NAME Emma Virginia Burdette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO			
17. INFORMANT Eugene F Mullinix				Address Seabrook Acres, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Coronary Occlusion with acute Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease (c) INTERVAL BETWEEN ONSET AND DEATH Months Several years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 1955 to April 21, 1957, that I last saw the deceased alive on April 20, 1957, and that death occurred at 3:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James K. North M.D.				ADDRESS (Street, city or town, state) RFD Bowie Md 4/21/57			
PHYSICIAN'S NAME (Type) H. James North							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Calmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Jones				ADDRESS 4420 E. Baltimore St		24a. REC'D BY REGISTRAR APR 22 1957	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. S.

4370

CERTIFICATE OF DEATH

04394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Claude</u> First <u>N</u> Middle <u>Norton</u> Last		4. DATE OF DEATH <u>April</u> Month <u>19</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1889</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARCHITECT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE, CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM E NORTON</u>		14. MOTHER'S MAIDEN NAME <u>MARY E SITTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4002 Crittenden St</u>	
17. INFORMANT <u>Claude R Norton</u> Address <u>Hyattsville, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biliary cirrhosis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of stomach - metastases</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>57</u> to <u>4/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Howard S. Madigan</u> M.D. <u>6480 New Hampshire Ave.</u> ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Howard S. Madigan, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>4-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	
22d. LOCATION (City, town, or county) <u>Wash., D.C.</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>1400 Chapin St N.W.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>A.W. Francis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. 11

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Camden			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b 1 Hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pennsauken		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hosp.				d. STREET ADDRESS 7502 Rogers Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL JOSEPH OFFENBACHER				4. DATE OF DEATH Month April Day 22 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 Oct. 1953		9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hurley F. Offenbacher				14. MOTHER'S MAIDEN NAME Patricia A. Lerner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Patricia A. Offenbacher Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured skull DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child was struck by an automobile while crossing street.					
20c. TIME OF INJURY Month, Day, Year 4-2-57 Hour 4:59 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Beltsville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 2, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-5-1957		22c. NAME OF CEMETERY OR CREMATORY Waco Cemetery		22d. LOCATION (City, town, or county) (State) Waco, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly				ADDRESS 131-11th St		24a. REC'D BY REGISTRAR James J. Jones	
				24b. REGISTRAR'S SIGNATURE			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04396

Reg. Dist. No.

4372

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1119 57th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Andrew Middle Carnegie Last Palmer				4. DATE OF DEATH Month April Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1907	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 4 Days 9		11. IF UNDER 24 HRS. Hours 4 Min. 9			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ulysses Palmer				14. MOTHER'S MAIDEN NAME Cordee Patrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Zenorra Palmer; same address		17. INFORMANT Address Zenorra Palmer; same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (c) Cardiovascular renal disease DUE TO cause last, stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 8, 1957.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-13-57		22c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL		22d. LOCATION (City, town, or county) (State) SUITLAND, P.G. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Colleen T. Jones				ADDRESS 414-15th S.E.		24a. REC'D BY REGISTRAR DATE APR 10 1957	
				24b. REGISTRAR'S SIGNATURE W. J. S. S. S.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4345

CERTIFICATE OF DEATH

04397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3808 Nicholson St				d. STREET ADDRESS 3808 Nicholson St			
3. NAME OF DECEASED (Type or print) LILLIE PARISH				4. DATE OF DEATH April 7 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1882	
				9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Samuel Tubbs				14. MOTHER'S MAIDEN NAME ? Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Norman J. Parish				Address 6001 44th ave Hyattsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Delphi		(County) (State)	
21. I certify that I attended the deceased from 3:25-1957 to 4-7-1957, that I last saw the deceased alive on 4-7-1957, and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.D. Bauer MD.				ADDRESS (Street, city or town, state) M.D. 3513 Buck Lodge Rd. Delphi			
DATE SIGNED 4-7-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE APR 11 1957		24b. REGISTRAR'S SIGNATURE James L. [Signature]	

RECEIVED
APR 11 1957
BUREAU W. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

44 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04398

Reg. Dist. No.

24 d

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b 54 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) H. Green Road (14427)		e. STREET ADDRESS 40 Area Road (14427)	
3. NAME OF DECEASED (Type or print) James Henry Pinkney		4. DATE OF DEATH April 3 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1901
9. AGE (In years last birthday) 55 yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Pinkney		14. MOTHER'S MAIDEN NAME Susan Spragg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Eleanor Barnett, 40 Area Road, Forestville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-6-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Germantown Md SE AIC	
23. FUNERAL DIRECTOR'S SIGNATURE Henry L. Washington		ADDRESS 467 N. St. NE	
24a. REC'D BY REGISTRAR DATE APR 12 1957		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. A. 3

APR 9 1957

RECEIVED

4373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH. 28			
c. LENGTH OF STAY IN 1b 13 Days				d. STREET ADDRESS 1011 COUNTY RD. S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGE'S GEN. HOSP.				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
BESSIE VIRGINIA		PLAUGER		APRIL		14 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-95	9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Work at Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jackson Dinges				14. MOTHER'S MAIDEN NAME Mary Burner Dinges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Ashby Lee Plauger 10-II County RD S'E			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of Lung 16.3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Cause undetermined) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-3 , 19 57 , to 4-14 , 19 57 , that I last saw the deceased alive on 4-13-57 , 19 57 , and that death occurred at 1:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard S. Madigan M.D.				ADDRESS (Street, city or town, state) 6480 New Hampshire Ave. Hyattsville, Md.			
PHYSICIAN'S NAME (Type) Howard S. Madigan				DATE SIGNED 4/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/1957		22c. NAME OF CEMETERY OR CREMATORY Plauger Cemetery		22d. LOCATION (City, town, or county) (State) Detrick Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE APR 22 57		24b. REGISTRAR'S SIGNATURE W. L. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 22 1957

RECEIVED

4416

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro				c. LENGTH OF STAY IN 1b 42 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Largo Road				e. STREET ADDRESS Largo Road.			
3. NAME OF DECEASED (Type or print) First Thomas Middle Henry Last Proctor				4. DATE OF DEATH Month April Day 22, Year 19 57.			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1870	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS Months Days Hours Min. 	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)
10b. KIND OF BUSINESS OR INDUSTRY Tenant			11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Proctor			14. MOTHER'S MAIDEN NAME Mollie Savoy				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Mary Proctor (Wife)			Address Upper Marlboro, Maryland.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatitis							INTERVAL BETWEEN ONSET AND DEATH unk
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Summer, 1950, to 22 Apr., 1957, that I last saw the deceased alive on 22 Apr., 1957, and that death occurred at 5:20 M. from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE R B Sasscer		M.D. Upper Marlboro, MD		DATE SIGNED 4-24-57			
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		Upper Marlboro, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR APR 25 57		24b. REGISTRAR'S SIGNATURE Wesley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4374

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5702 30th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Luther Last Reid			4. DATE OF DEATH Month April Day 20 Year 19 1957		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1881		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Samuel Reid		
14. MOTHER'S MAIDEN NAME Florence			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Edwin Luthor Reid; Silver Springs, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause lost, (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove	
22d. LOCATION (City, town, or county) Herndon, Va.		22e. (State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home		ADDRESS 1st Rainier		24a. REC'D BY REGISTRAR APR 25 '57	
24b. REGISTRAR'S SIGNATURE John T. Maloney					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

1957

RECEIVED

4375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If inst. before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>6102 58th Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Richards</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 April 1957</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilton Richards</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Nies</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital records</u>		Address <u>Cheverly Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abnormal pulmonary ventilation</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia, (2 Abs.)</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park, Md.</u> DATE SIGNED <u>4/4/57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>		<u>College Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 57</u>	
24b. REGISTRAR'S SIGNATURE <u>John Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1957

BUREAU V. S.

4346

CERTIFICATE OF DEATH

Reg. Dist. No. **245**

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
c. LENGTH OF STAY IN 1b 5 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4100 Oglethorpe Street				d. STREET ADDRESS 4100 Oglethorpe Street			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPHINE SAVITSKI (Jozefa Sawicka)				4. DATE OF DEATH April 4th, 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15th, 1875	
				9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Poland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew Newicz				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Helen S. Kiess, 4100 Oglethorpe St. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause anox +							
4300.0 DUE TO Generalized arteriosclerosis x senility							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis x senility							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1912 , to 4-4 , 19 57 , that I last saw the deceased alive on 3-31 , 19 57 , and that death occurred at 10:40 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ronald S. Fleischer M.D.				5432 Queens Chapel Road, 4/4/1957			
PHYSICIAN'S NAME (Type) Ronald S. Fleischer				West Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR DATE April 8 1957		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

MEDICAL CERTIFICATION

1. THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: Attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be retained by the registrar.

RECEIVED
APR 11 1957
J. A. M. J.

4378

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPE IX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILLUM TERRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First S. Middle HEBERT Last SCHAEFER		4. DATE OF DEATH Month APRIL Day 18 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-03
9. AGE (In years last birthday) yrs 54		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Cashier & Ass't. Mgr. Bank		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Schaefer		14. MOTHER'S MAIDEN NAME Mary Schaeffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 577-22-2097	
17. INFORMANT Mrs. Ethel Boyd Schaefer		Address 611 Somerset Pl. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) myocardial infarct		INTERVAL BETWEEN ONSET AND DEATH 1 day months 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 57 , to April 18, 1957 , that I last saw the deceased alive on APRIL 17, 1957 , and that death occurred at 4:20 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 Sherrison St. Hyattsville Maryland DATE SIGNED 4-18-57			
ACTUAL SIGNATURE Arnold A. Lee M.D.			
PHYSICIAN'S NAME (Type) Arnold A. Lee			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/20/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Davis Co., Washington D.C.		24a. REC'D BY REGISTRAR APR 23 57	
24b. REGISTRAR'S SIGNATURE Rebecca			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04405

4377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Maryland				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier, Maryland			
f. STREET ADDRESS 3362 Chillum Road,.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Needham Middle Bascom Last Scott				4. DATE OF DEATH Month April Day 22 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1916	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Burner Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Key Company		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Scott				14. MOTHER'S MAIDEN NAME Ruby Spear			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Mrs Dora Scott Mt Rainier Maryland. (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic hepatitis DUE TO XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Absorption of chemicals used in cleaning.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. Apr. 15 p. m. 19 57				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Various places at which deceased worked.				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney NAME (Type) John T. Maloney, M.D.				DATE SIGNED April 22, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 2/23/57			
22c. NAME OF CEMETERY OR CREMATORY Edwards Funeral Home				22d. LOCATION (City, town, or county) (State) Kinston Lenoir Co., N. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				24. REC'D BY REGISTRAR APR 25 57			
ADDRESS Hyattsville, Md.				24. REGISTRAR'S SIGNATURE W. L. Smith			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

13 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 1-1-57 83
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4378
 CERTIFICATE OF DEATH

04406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.	
c. LENGTH OF STAY IN 1b 5 Days		d. STREET ADDRESS 4702 Riverdale, Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nola Middle Sherman Last		4. DATE OF DEATH Month April Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1900
9. AGE (In years last birthday) 57		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William N Sherman		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause for line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Cardiovascular Disease (c) Renal Disease			INTERVAL BETWEEN ONSET AND DEATH 5 days 20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 2, 1954, to 4-24, 1957, that I last saw the deceased alive on 4-24-57, and that death occurred 9:00A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Clum		ADDRESS (Street, city or town, state) 6110 43rd Ave	
PHYSICIAN'S NAME (Type) Dr. Clum		DATE SIGNED 4-25-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/57	22c. NAME OF CEMETERY OR CREMATORY Morgan Cemetery	22d. LOCATION (City, town, or county) (State) Woodbine Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frederic H. Smith		24a. REC'D BY REGISTRAR DATE APR 29 57	24b. REGISTRAR'S SIGNATURE O. J. Smith

RECEIVED
JUN 10 1957
BUREAU V. S.

4417

CERTIFICATE OF DEATH

Reg. Dist. No.

734

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO'S. CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDLY		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 7650- Allentown Road S.E.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROSANNA S. SHIPLEY		4. DATE OF DEATH Month Day Year April 10th 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 16th 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Sellner		14. MOTHER'S MAIDEN NAME Mary E. Biggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Mrs. Minnie L. Goodwin	
17. INFORMANT Minnie L. Goodwin		Address 7650- Allentown Road S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X Due to Hypertensive Heart Disease & myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Atherosclerosis of coronary arteries & Right Ventricle hypertrophy (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 10 days 7 yrs. 7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1956 to 4-10-1957 that I last saw the deceased alive on 4/9/1957 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Anna Coyne Todd 7519- Broadview Road, Friendly, Md. 5/10/57 ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) ANNA COYNE TODD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12-57	
22c. NAME OF CEMETERY OR CREMATORY Bells Cemetery		22d. LOCATION (City, town, or county) (State) Camp Springs, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		24a. REC'D BY REGISTRAR APR 11 1957	
24b. REGISTRAR'S SIGNATURE Carrie Campbell		24c. ADDRESS 1661 - Good Hope Road S.E. Washington, D.C.	

MEDICAL CERTIFICATION

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
1957 11 11
STANTON

4418

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4601--Lewis Ave.				e. STREET ADDRESS 4601--Lewis Ave.			
3. NAME OF First Middle Last (Type or print) MARGARET E. SIMPSON				4. DATE OF DEATH Month Day Year April 21 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3-1884	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Alfred McWilliamson				14. MOTHER'S MAIDEN NAME Mary L. Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT George F. Simpson -4601-Lewis Ave Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion Cachexia & Toxemia</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>abdominal Carcinomatosis</u> DUE TO (c) <u>(primary Site Kidney)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-7-</u> , 19 <u>56</u> , to <u>April 21</u> , 19 <u>57</u> that I last saw the deceased alive on <u>March 26</u> , 19 <u>57</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward A. Palank</u> M.D. 52035.1401 N. L. Rd SE				DATE SIGNED <u>4/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Edward A. PALANK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-23-57</u>		<u>Green Hill</u>		<u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simone Bros.</u>				ADDRESS <u>1661--Good Hope Rd., SE Washington, DC</u>		24a. REC'D BY REGISTRAR <u>APR 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

4419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vista</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vista</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James</u> <u>Issac</u> <u>Snowden</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>17</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1898</u>
9. AGE in years (last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Snowden</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-36-0002</u>	
17. INFORMANT <u>Mary E. Snowden</u>		Address <u>Vista, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart failure</u> DUE TO (c) <u>Atherosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>55</u> , to <u>April 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>57</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Dr. Henry A. Wise, M.D. 9005 Volta St. Lanham, Md.</u>			
ACTUAL SIGNATURE <u>Dr. Henry A. Wise, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>4-22-51</u>	<u>4-22-51</u>	<u>Holy Family</u>	<u>Woodman, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		ADDRESS <u>467 N. St. N. W. Wash</u>	24a. REC'D BY REGISTRAR <u>2 APR 23 1957</u>
		24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 23 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4420

CERTIFICATE OF DEATH

04410

Reg. Dist. No.

234

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland				c. LENGTH OF STAY IN 1b 9 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland			
				d. STREET ADDRESS 6500- Circle Drive S.E.			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last NELLIE SOUTHERLAND				4. DATE OF DEATH Month Day Year April 28th. 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4-1879	
				9. AGE (in years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Thomas				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
				17. INFORMANT Address Lillian S. Prinkey - 6500- Circle Drive S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular disease</u> 10 YEARS							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 18, 1954</u> to <u>April 28, 1957</u> that I last saw the deceased alive on <u>April 25, 1957</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vitale H. Paganello</u> M.D. <u>4912 Deal Dr. Wash 21, D.C.</u>				DATE SIGNED <u>April 28, 1957</u>			
PHYSICIAN'S NAME (Type) <u>VITALE H. PAGANELLO, M.D.</u>				<u>4912 DEAL DR. WASH 21 DC.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1st 1957		22c. NAME OF CEMETERY OR CREMATORY Chicamuxen Cemetery		22d. LOCATION (City, town, or county) (State) Chicamuxen, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>				ADDRESS 1661- Good Hope Road SE Washington 20, D.C.		24a. REC'D BY REGISTRAR DATE MAY 1 1957	
				24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01411
45

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6000--48th Avenue		d. STREET ADDRESS 6000--48th Avenue	
3. NAME OF DECEASED (Type or print) First MARION Middle ODEN Last SOWERS		4. DATE OF DEATH Month April Day 26th Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4th, 1880
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader (Retired) PEPCO		10b. KIND OF BUSINESS OR INDUSTRY Salem, Missouri	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel Sowers		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 577-05-0558	
17. INFORMANT Roy Sowers		Address 6000--48th Ave. Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 440.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) One hour INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956 to April 25 1957 , that I last saw the deceased alive on 4-26 1957 , and that death occurred at 12:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. HYATTSTVILLE, MD. DATE SIGNED			
ACTUAL SIGNATURE Till Bergemann M.D.		DATE SIGNED 4-31-57	
PHYSICIAN'S NAME (Type) TILL BERGEMANN		DATE SIGNED 4-31-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1957	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suittland, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE Apr. 4, 1957	
24b. REGISTRAR'S SIGNATURE Mr. Jas. Sowers		24c. REGISTRAR'S SIGNATURE Mr. Jas. Sowers	

RECEIVED

MAY 6 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register of vital statistics, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4380

CERTIFICATE OF DEATH

04412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hgts. Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>		d. STREET ADDRESS <u>7016 59th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Ann</u> Last <u>Sorrigs</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-54</u>
9. AGE (In years last birthday) <u>2</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child-None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father-Andrew Spriggs-7016-59th Pl, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Meningitis</u> DUE TO <u>Causative Organisms</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Undetermined</u> DUE TO (c) <u>Undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 2, 1957</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jolene Perkins</u>		ADDRESS (Street, city or town, state) <u>5301 Hamilton St., Hyattsville</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Perkins</u>		DATE SIGNED <u>4-2-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-5-57</u>	<u>Lincoln Memorial</u>	<u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Rollins</u>		24a. REC'D BY REGISTRAR <u>APR 5 '57</u>	
ADDRESS <u>4339 Hunt Pl, NE</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

RECEIVED

APR 5 1900

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04413

Reg. Dist. No.

734

4421

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek				c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annandale 33X...	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 211				d. STREET ADDRESS Box 895 Brook Hill Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (JACK) John Edward Stein				4. DATE OF DEATH Month April Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1923	
9. AGE (In years last birthday) 33 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pilot		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jack P. Stein				14. MOTHER'S MAIDEN NAME Marie M. Messner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 577-22-7864		17. INFORMANT Jack P. Stein, same as no. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 823X Conditions, if any, which gave rise to immediate cause (b) Fracture of the skull, crushed chest and abdomen (c) Fractures of both femurs, right forearm DUE TO 823X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of an automobile that ran off the road and struck tree							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of an automobile that ran off the road and struck tree					
20c. TIME OF INJURY Month, Day, Year 11:50 p. m. 4/11/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 211		20f. (City or town) (County) (State) Accokeek P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried				22b. DATE THEREOF 4-16-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
				22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR APR 17 1957	
				24b. REGISTRAR'S SIGNATURE Carrie Campbell			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or with the burial, cremation, or removal.

BUREAU V. S.

APR 17 1907

RECEIVED

4381

CERTIFICATE OF DEATH

04414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>				c. LENGTH OF STAY IN 1b <u>17 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Maryland X.</u>			
				d STREET ADDRESS <u>7730 Finn Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Strohl</u> Last <u>Strohl</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24 1907</u>		9. AGE (In years last birthday) <u>49</u> yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joel F. Strohl</u>				14. MOTHER'S MAIDEN NAME <u>Clara Ballenger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James Strohl (Nephew)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 wks</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>57</u> , to <u>4/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/3</u> , 19 <u>57</u> , and that death occurred at <u>1:20 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Kauffman</u> , M.D.				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <u>Dr. J. Kauffman</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>3200 N.I. Ave. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 8 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. ST.

APR 3 1957

RECEIVED

4422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY Prince Georges'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Snowden Woodrow First Sweeney Middle Sweeney Last		4. DATE OF DEATH Month April Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1912
9. AGE (In years last birthday) 44 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 11 Hours 11 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed Chaufer		10b. KIND OF BUSINESS OR INDUSTRY State Roads Comm.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Snowden Sweeney		14. MOTHER'S MAIDEN NAME Ida Vermillion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 711-07-2570	
17. INFORMANT Mrs. Snowden W. Sweeney- Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Obesity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Apr , 19 57 , to 11 Apr , 19 57 , that I last saw the deceased alive on 11 Apr , 19 57 , and that death occurred at 11:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasscer		DATE SIGNED 12 Apr 57	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		ADDRESS (Street, city or town, state) Upper Marlboro Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem: Fort Myer.		22d. LOCATION (City, town, or county) (State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR 17 1957	
24b. REGISTRAR'S SIGNATURE d. H. Seducks			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 17 1937

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4423

CERTIFICATE OF DEATH

Reg. Dist. No.

04416
243

1. PLACE OF DEATH a. COUNTY <i>Pr Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>901 Maple Ave</i>		e. STREET ADDRESS <i>901 Maple Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Wade</i> Middle <i>Sweeney</i> Last <i>Sweeney</i>		4. DATE OF DEATH Month <i>April</i> Day <i>17</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 18, 1884</i>
9. AGE (In years last birthday) <i>73</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck for man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail road</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Pinkney Sweeney</i>		14. MOTHER'S MAIDEN NAME <i>Alice Hardy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>2</i>	
17. INFORMANT <i>Mary E. Sweeney</i>		Address <i>Bowie Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinomatosis</i> DUE TO (b) <i>Cancer of Prostate</i> DUE TO (c) <i>Cancer of Prostate</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>1 year</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 1</i> , 19 <i>40</i> , to <i>April 17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4/16/57</i> , 19 <i>57</i> , and that death occurred at <i>6 A. M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert S. McCeney</i> M.D.		ADDRESS (Street, city or town, state) <i>402 Main Street,</i> DATE SIGNED <i>4/17/57</i>	
PHYSICIAN'S NAME (Type) <i>Robert S. McCeney, M.D.</i>		<i>Laurel, Maryland.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/19/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Barnabas Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Leland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. L. Sore</i> ADDRESS <i>Hyattsville, Md</i>		24. REGISTRAR'S SIGNATURE <i>Agnes Yingling</i>	

MEDICAL CERTIFICATION

1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. S.

DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croome</u>	
c. LENGTH OF STAY IN 1b <u>50 years</u>		d. STREET ADDRESS <u>Sager Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Winfield Jayman</u>		4. DATE OF DEATH Month Day Year <u>April 16 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1873</u>
9. AGE (in years last birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY (Own or not) <u>Tobacco Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>	
13. FATHER'S NAME <u>Zadock Jayman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Oggle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not in file</u>	
17. INFORMANT <u>Not in file</u>		Address <u>Minister M. Jayman, same as no 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>442X</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 16, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Croome, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24. REGISTRAR'S SIGNATURE <u>A. D. Adair</u>	

BUREAU V. E.

APR 22 1957

RECEIVED

4382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2</u> hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 April 1957</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William F Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Webber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address <u>Cheverly Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Anoxia</u> (c) <u>Anoxia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1151</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M Frawley</u>				ADDRESS (Street, city or town, state) <u>6805 Baltimore Boulevard</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. Frawley</u>				DATE SIGNED <u>College Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1007244XVC

BUREAU V. S.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 11-13-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04419

245

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b Hyattsville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5805 Queens Chapel Rd. Sacred Heart Home		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Washington, D. C. d. STREET ADDRESS 5805 Queens Chapel Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NOMA Middle M. Last THOMPSON		4. DATE OF DEATH Month April Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/71
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 0 Days 6	IF UNDER 24 HRS. Hours 6 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Secy.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benedict Thompson		14. MOTHER'S MAIDEN NAME Alice Lawn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Charles W. Thompson 7906 Riverside Dr., Cabin John, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) arteriosclerosis generalized		INTERVAL BETWEEN ONSET AND DEATH One day 2 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1 , 19 57 , to April 7 , 19 57 , that I last saw the deceased alive on April 7 , 19 57 , and that death occurred at 9:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F Collins		ADDRESS (Street, city or town, state) 322 - H St NE	
PHYSICIAN'S NAME (Type) THOMAS F COLLINS M.D.		DATE SIGNED 4-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR April 9 1957		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severie Refused	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 11 1957
BUREAU V. E.

4383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro,</u>			
c. LENGTH OF STAY IN 1b <u>1 Hr.</u>				d. STREET ADDRESS <u>Box 127</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Darlene</u> First Middle Last <u>XXXXXX</u> <u>Tippett</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1957</u>	
9. AGE (In years last birthday) yrs <u>7</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Benjamin Clarence Tippett</u>			
14. MOTHER'S MAIDEN NAME <u>Geneva Kidwell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Upper</u> <u>Benjamin Clarence Tippett-Marlboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abnormal pulmonary ventilation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia (lived 1 hr.)</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY FORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 3, 1957</u> , to <u>April 3, 19 57</u> that I last saw the deceased alive on <u>April 3</u> <u>19 57</u> , and that death occurred at <u>9:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.				ADDRESS (Street, city or town, state) <u>College Park, Md.</u>			
DATE SIGNED <u>4/4/57</u>							
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>				College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/6/57</u>		<u>Mt. Carmel Cem.</u>		<u>Upper Marlboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Bros Upper Marlboro</u>				24a. REC'D BY REGISTRAR DATE <u>APR 8 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Bros</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1957

RECEIVED

4384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 5205 Edgewood Rd.			
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Verhevnik				4. DATE OF DEATH Month April Day 19 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 April 1957		9. AGE (In years last birthday) yrs 1 Months 4 Days 4 Hours Min 	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John William Verhevnik				14. MOTHER'S MAIDEN NAME Neva Juanita Wanderon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary by a line, isocalcane 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity, (birth wt 2 lbs) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cheverly Park DATE SIGNED 4/19/57							
ACTUAL SIGNATURE Thomas A. Christensen M.D.							
PARTICIPANT NAME (Type) Thomas A. Christensen							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 1957		22c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery		22d. LOCATION (City, town, or county) (State) Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Alvin W. Ramm				ADDRESS Adin		24a. REC'D BY REGISTRAR MAY 1 57	
24b. REGISTRAR'S SIGNATURE W. J. Ramm							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7321XVC

RECEIVED

MAY 3 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 2222 1 st. Street, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Luther First Walk Jr. Last		4. DATE OF DEATH April 8 Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1935
9. AGE (In years last birthday) 21 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY D. C. Govt.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luther Walk Sr.		14. MOTHER'S MAIDEN NAME Daisy Allis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 250-50-8591	
17. INFORMANT Address Rozina Walk Same as # 2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral laceration (c) Fracture of skull		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with an auto, telephone pole and tree,	
20c. TIME OF INJURY Month, Day, Year 11.00 a. m. 7- 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Street	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ardmore, Pr. Geo. Maryland		20f. (City or town) pole and tree, (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 8, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4-11-57	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Wray Court D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Frager's Funeral Home Inc.		24a. REC'D BY REGISTRAR APR 10 1957	
ADDRESS 389 E. Ave SE		24b. REGISTRAR'S SIGNATURE Deedman	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4386

CERTIFICATE OF DEATH

04423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,				c. LENGTH OF STAY IN 1b 22 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. STREET ADDRESS 1817 Columbia Ave.,			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine VIRGINIA West				4. DATE OF DEATH Month Day Year April 20 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 17, 1875	9. AGE (In years last birthday) 82 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESS MAKER (LATER) CLERK				10b. KIND OF BUSINESS OR INDUSTRY WOOLWORTH CO		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME JAMES W. WEST				14. MOTHER'S MAIDEN NAME FRANCES BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 578-34-0803			
17. INFORMANT MRS MARGARET ROBINSON				Address 1817 COLUMBIA AVE. LANDOVER, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from April 10 , 19 57 , to April 21 , 19 57 , that I last saw the deceased alive on April 20 , 19 57 , and that death occurred on April 21 , 19 57 , at 4-35P M, from the causes and on the date stated above. ACTUAL SIGNATURE Leon Levitsky M.D. ADDRESS (Street, city or town, state) DATE SIGNED 4/21/57							
PHYSICIAN'S NAME (Type) Dr. Leon Levitsky							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-24-1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Washington, D.C.				24a. REC'D BY REGISTRAR DATE APR 23 57		24b. REGISTRAR'S SIGNATURE Paul Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4387

CERTIFICATE OF DEATH

04424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 9223 Baltimore Ave.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Irving,		Middle M.		Last Weed	
4. DATE OF DEATH		Month April		Day 3		Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-85		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY machinist		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Weed				14. MOTHER'S MAIDEN NAME Mary L Mallory			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 198012743		17. INFORMANT Pauline Weed College Park, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Occlusion of left coronary artery DUE TO (c) Coronary Atherosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1957 to April 1957 , that I last saw the deceased alive on April 1957 , and that death occurred at 10:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Walcott Etienne		M.D.		ADDRESS (Street, city or town, state) 4413 Vermont St. College Park, Md. 44/57			
PHYSICIAN'S NAME (Type) Dr. Walcott Etienne							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4/6/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR APR 8 57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01425

Reg. Dist. No. 245

4348

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN lb 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3218 Chillum Road, Apt 302				d. STREET ADDRESS 1734 Evarts Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sabina First Windel Middle Last				4. DATE OF DEATH Month April Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1894	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Schnell				14. MOTHER'S MAIDEN NAME ? ? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT William H. Windel Address 3218 Chillum Road Mt. Rainier, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 449X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Renal disease. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 18, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1957		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Hines Co., Washington, D.C.				24a. REC'D BY REGISTRAR DATE 23 1957		24b. REGISTRAR'S SIGNATURE James Severy	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 20 1967

RECEIVED

Item 11, Film 6213 -11-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4388
CERTIFICATE OF DEATH

04426

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
c. LENGTH OF STAY IN 1b 8 days				d. STREET ADDRESS 5021 Oglethorpe Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Wood				4. DATE OF DEATH Month April Day 2 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-01	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Albert J. Wood				14. MOTHER'S MAIDEN NAME Eva M. Putnam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 177 09 1548		17. INFORMANT Charles W. Wood Address Same as # 2	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 25 min 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from 3/28/57 , 19 57 , to 4/2 , 19 57 , that I last saw the deceased alive on 4/2 , 19 57 , and that death occurred at 4:30 PM, from the causes and on the date stated above.				
ACTUAL SIGNATURE Charles A. Hufnagel M.D. 3800 Reservoir Rd. N.W. Washington				DATE SIGNED 4/2/57			
PHYSICIAN'S NAME (Type) Charles A. Hufnagel							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR APR 5 57		24b. REGISTRAR'S SIGNATURE [Signature]	

APR 5 1957

4389

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN 1b 51 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Zeller Last Zeller				4. DATE OF DEATH Month April Day 21 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1870	9. AGE (In years last birthday) yrs. 86	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret L. Blatz 381 Beverly Place Beverly Beach Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized, severe 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH unk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Jan , 19 57 , to 21 Apr , 19 57 , that I last saw the deceased alive on 20 Jan , 19 57 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED RRD Jarner M.D. Upper Marlboro Md 4-21-57							
ACTUAL SIGNATURE RRD Jarner M.D. Upper Marlboro Md 4-21-57							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4-24-57		Prospect Hill		Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home				ADDRESS 4812 Ga Ave NE		24a. REC'D BY REGISTRAR WASH DC	
				24b. REGISTRAR'S SIGNATURE WASH DC		DATE APR 22 57	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED